MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-00)

CERTIFICATE OF DEATH

04076

Reg. Dist. No. 72

1. PLACE OF DEATH:
County Carroll
City or town Myers Dist. Westminster, Md. R.D.1
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 44 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Md R.D.1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Noah Nathanial Arter

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Martha (Myers) Arter
6(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Oct. 10 1865

8. AGE: Years	Months	Days	If less than one day
74	6	6	hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual occupation Mill Operator
11. Industry or business Flour & Feed Mill

FATHER
12. Name Enos Arter
13. Birthplace Maryland

MOTHER
14. Maiden name Susanna Mayers
15. Birthplace Maryland

16. Informant Mrs. Martha Arter
Address Westminster, Md. R.D.1

17. Burial Date thereof April 19 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Silver Run, Md.

18. Funeral director J. M. Little & Son
Address Littlestown, Pa R.D.2

19 April 18th 1940 Calvin E. Bankert, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1940, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1940, to April 16 1940, and that I last saw h was alive on April 16 1940.

Immediate cause of death Coronary Occlusion — DURATION 10 hrs.

Due to

Due to

Other conditions Chronic myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Ot operations
Ot autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE L. L. Potter M.D.
M. D. or other
Address Littlestown, Pa Date signed 4-17-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAY 4 1940
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-B)

CERTIFICATE OF DEATH

04077

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Eldersville Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Florence Goldie Barnes

3. (b) Social Security Number ##

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Emory Barnes

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1885

8. AGE: Years	Months	Days	If less than one day
55	2	17	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Burgess Hughes

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Minnie Hellman

MOTHER 15. Birthplace Md.

16. Informant Mr. Emory Barnes

Address Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-7-40 (month) (day) (year)

Cemetery or crematory Freedom Cemetery

Location Eldersburg Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. 4-5-40 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1940, at 8:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 19 , to 4-5 1940, and that I last saw her alive on 4-5-40 19

Immediate cause of death	DURATION
Uremic nephritis	
chronic arteriosclerosis	
Due to chronic hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. T. Lawson M.D.
M. D. or other

Address Sykesville Date signed 4/5/40.

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

04078

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Rural near Gamber
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 24 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R.D. #1 Sykesville, Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: William H. Barnes

3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 6, 1888

8. AGE: Years: 52 Months: 1 Days: 20 If less than one day: hrs. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER
12. Name: Lloyd Barnes
13. Birthplace: Maryland.
MOTHER
14. Maiden name: Ida Jane Williams
15. Birthplace: Maryland
16. Informant: Mr. Lloyd Barnes
Address: R.D. Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30, 1940 (month) (day) (year)
Cemetery or crematory: Mt. Pleasant
Location: Gamber, Carroll Co. Md
18. Funeral director: C M Waltz
Address: Winfield Md
19. 4/25 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

Prior to
20. DATE OF DEATH: April 26 1940, at 12 M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —,
and that I last saw h — alive on — 19 —.

Immediate cause of death: Cerebral Hemorrhage
Due to: Arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy: None

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Jas. T. Marsh Deputy Medical Exam
M. D. or other
Address: Mt Winsor Md Date signed: 4/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CEIVED
MAY 4 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04079

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Carroll

City or town Sykesville, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 5 years 9 days

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 104 Market Place

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Berlowitz

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 - 1901

8. AGE:

Years	Months	Days	If less than one day
38	9 mo		hrs. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Samuel Berlowitz

13. Birthplace Russia

MOTHER

14. Maiden name Jennie Meisel

15. Birthplace Russia

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial Date thereof 4-25-40

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington Road Cemetery

Location Washington Blvd.

18. Funeral director Jack Lewis Inc.

Address Balto & Carolina St Balto, Md.

19. 4-24-40 19 C. Harry Weed

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1940, at 6.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1940, to April 24 1940, and that I last saw him alive on April 24 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 25-1940
Due to	
Due to	
Other conditions Dementia Praecox Paranoid Type -	1935

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Berger M.D.

M. D. or other

Address Sykesville, Md. Date signed April 24-40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94a)

04080

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 6 mos., 25 days

Stay in this community (yrs., or mos., or days): 6 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 2719 Baker St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Carrie A. Biser

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

8 (b) Name of husband or wife: Benjamin F. Biser

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1869

8. AGE: Years: 71 | Months: 2 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Piedmont, W. Va.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER

12. Name: Abner Keller

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Kuter

15. Birthplace: W. Va.

16. Informant: J. E. Reister

Address: 2719 Baker St. Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 22, 1940 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn Md.

18. Funeral director: Wm. J. Tichnor & Sons

Address: North & Pa Ave Balto Md.

19. Apr 20 1940 (Date rec'd by registrar) C. Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1940, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1939, to April 20, 1940, and that I last saw h- alive on April 20 1940.

	DURATION
Immediate cause of death: Coronary Thrombosis	1 day
Arteriosclerotic heart disease	2 mos.
Due to: Generalized arteriosclerosis	7 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Joseph H. Marshall, MD M. D. or other

Address: Springfield State Hospital Date signed 4-26-40

RECEIVED
MAY 4 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04081

1. PLACE OF DEATH

County Carroll (46-D) Registration Dist. No. 74

Village or City Eldersburg, Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Emma Perrine Block

(a) Residence: No. Eldersburg Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Herman Block

6. DATE OF BIRTH (month, day, and year) Dec. 25th, 1863

7. AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	76	3	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. At Home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Perrine

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Not Known

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT (Address) Mrs. C. W. Adams Eldersburg Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Parkwood Cemetery Date 4/13/1940

19. UNDERTAKER (Address) E. I. Fanning & Son 1938 E. Lafayette Ave.

20. FILED 4-11, 1940 C. Harry Weer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 11 (Month) (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1939, 19__, to death, 19__

I last saw her alive on 4/11, 1940; death is said to have occurred on the date stated above, at 11:30 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Rectum	

Other Contributory Causes of importance:

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of Injury ___, 19__

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ___

(Signed) W. H. Lawson M. D.

(Address) Sykesville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastrocolitis	*1 year*

RECEIVED
APR 20 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

04082

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Silver Run Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry B. Bollinger

3. (b) Social Security Number none

4. Sex m

5. Color or race W

6. (a) Single, married, widowed, or divorced widower

6 (b) Name of husband or wife Bessie Bollinger

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1883

8. AGE: Years 56 Months 9 Days 4 If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Emanuel Bollinger

13. Birthplace Md

MOTHER 14. Maiden name Agusta Reck

15. Birthplace Md

18. Informant Mrs Wilbur Sherfey

Address New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27, 1940 (month) (day) (year)

Cemetery or crematory Cemetery

Location Baust

18. Funeral director C. O. Fussel Son

Address Taney Town, Md.

19. April 27 1940 (Date rec'd by registrar) Ernie G Benedict Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1940, at 9 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939, to Apr 24 1940, and that I last saw him alive on Apr 23 1940.

Immediate cause of death Cardiac dilatation

Due to Paroxysmal tachycardia

Due to Chronic Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

DURATION

?

?

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide none Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jas. T. Marsh M D M. D. or other

Address New Windsor Md Date signed Apr 26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04083

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 month, 29 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1347 Ward Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Daniel Brown

3. (b) Social Security Number: 213-16-6501

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1921

8. AGE: Years	Months	Days	If less than one day
19	3	16	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Bootblack

11. Industry or business

FATHER
12. Name: Williams Brown
13. Birthplace: York County, Virginia

MOTHER
14. Maiden name: Elsie Thomas
15. Birthplace: Chestertown, Maryland

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21-1940 (month) (day) (year)
Cemetery or crematory Mt Calvary ~~April 21~~
Location Anne Arundel Co. Md
18. Funeral director Wheeler B Spriggs
Address 139 W Hamburg St
19. 4/17/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1940 19 12:10 P.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19, 1940 to April 17, 1940
and that I last saw him alive on April 17, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M. D.
Superintendent M. D. or other
Address Henryton, Maryland Date signed 4/17/40

RECEIVED
APR 24 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04084

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 yr., 27days, 7 mos.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Benedict Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mildred Louise Curtis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Lloyd Curtis
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, 1912

8. AGE: Years	Months	Days	If less than one day
27	9	29	hrs. min.

9. Birthplace: Charlotte Hall, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Thomas Stewart
13. Birthplace: Bird's Creek, Maryland

MOTHER
14. Maiden name: Fannie Bar
15. Birthplace: Bird's Creek, Maryland

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 25 1940 (month) (day) (year)
Cemetery or crematory
Location: Charlotte Hall, Maryland
18. Funeral director: Mrs. Samuel T. Hemsley
Address: 578 W. Biddle Street
19. 4/22/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1940 19 3:20 P.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26, 1938 to April 22, 1940, and that I last saw her alive on April 22, 1940

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 1938
Due to: --	
Due to: --	
Other conditions: --	
(Include pregnancy within 3 months of death)	
Major findings:	
Of operations: --	
Of autopsy: --	

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 4/22/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04085

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 months, 2 days.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Henderson Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Herman Dawson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Mary Dawson

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 4, 1882

8. AGE: Years	Months	Days	If less than one day
58	2	18	hrs. min.

9. Birthplace: Caroline County, Maryland (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business:

FATHER — 12. Name: Percy Dawson; 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary E. Benton; 15. Birthplace: Maryland

18. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/25/40 (month) (day) (year)

Cemetery or crematory: Union

Location: Near Greensboro Md.

18. Funeral director: R. B. Rawlings

Address: Greensboro Md.

19. 4/22/40 (Date rec'd by registrar) 19 Albert R. Swanhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1940 19 1:00 P.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20, 1940 19 to April 22, 1940 19; and that I last saw him alive on April 22, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 4/22/40

RECEIVED
MAY 4 1940
BUREAU V. S.

04086

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 25 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Sykesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry R. DeVries

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife Lou E. DeVries

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6th, 1871

8. AGE: Years	Months	Days	If less than one day
69	3	18	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Hardware

FATHER
12. Name John O. DeVries
13. Birthplace Md.

MOTHER
14. Maiden name Emily Wadlow
15. Birthplace Md.

16. Informant Mrs. Lou E. DeVries
Address Sykesville, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Apr. 28 1940
(month) (day) (year)

Cemetery or crematory Freedom

Location Carroll Co. Md.

18. Funeral director C. Harry Weer
Address Sykesville, Md.

19. Apr. 26 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1940, 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 19 to death 19
and that I last saw him alive on April 26 1940

Immediate cause of death Hypertension
Chronic myocarditis: duration: ten years.
Due to arteriosclerosis Coc. G.R.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. H. Lawson, M.D.
M. D. or other
Address Sykesville, Md. Date signed 4/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

CERTIFICATE OF DEATH

04087

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 10 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Tacoma Park Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 321 Greenwood Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Otis Doten

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hanna J -

6(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) March 3 - 1866

8. AGE:

Years	Months	Days	If less than one day
74	1	26	hrs. min.

9. Birthplace Camden, New York -
(Town, county, and state)

10. Usual occupation Monotype Operator -

11. Industry or business

FATHER 12. Name James O Doten

13. Birthplace New York -

MOTHER 14. Maiden name Viola E Howland

15. Birthplace New York

16. Informant Hospital Records

Address Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-30-40 (month) (day) (year)

Cemetery or crematory

Location Washington, D. C.

18. Funeral director The S.H. Hines Co

Address 2401-14th St. N.W. Wash. D. C.

19. Apr 29 1940 (Date rec'd by registrar) C. Harry Meier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1940, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1940, to April 29 1940, and that I last saw him alive on April 29 1940

Immediate cause of death	DURATION
Arteriosclerosis	Known July 1939
Chronic Myocarditis and	Known
Due to Myocardial Degeneration	April 1940
Due to Chronic Endocarditis	Known April 1940
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. M.D. or other

Address Sykesville, Md Date signed 4-29-40

RECEIVED
MAY 4 1940
BUREAU V. S.

04088

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 2 yrs., 6 mos., 19 days.
Stay in this community (yrs., or mos., or days) same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County #
City or town Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 212 S. Smallwood.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Richard Patrick Doyle.

3. (b) Social Security Number

4. Sex: Male.
5. Color or race: White.
6. (a) Single, married, widowed, or divorced: Married.
6 (b) Name of ~~husband or~~ wife Bertha Schlecht.
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Feb. 18, 1873.

8. AGE: Years 67. Months 2. Days 10. If less than one day ___ hrs. ___ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business General.

FATHER
12. Name Patrick Doyle.
13. Birthplace Ireland.

MOTHER
14. Maiden name Elizabeth Roach.
15. Birthplace Ireland.

16. Informant Springfield Hospital Records.
Address Sykesville, Md.

17. ~~Ken~~ Burial Date thereof April 27-40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory New Cathedral
Location Lyndhurst Rd
18. Funeral director Edward Foulson
Address 2359 Wash Blvd
19. 4-25-40 19 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1940, at 10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26, 1938, to April 24, 1940, and that I last saw him alive on April 24, 1940.

Immediate cause of death	DURATION
Cerebral Haemorrhage	4-24-40.
Due to Cerebral Arteriosclerosis prior to	10-5-37.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D.
M. D. or other
Address Sykesville, Md. Date signed 4/24/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (M) (I) (T)

RECEIVED
APR 26 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

04189

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Maple Grove Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 42 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Maple Grove Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary M. Ebaug.

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband ~~or wife~~: John Ebaug
6(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): August 10, 1875

8. AGE:

Years	Months	Days	If less than one day
64	7	22	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Keeps work

FATHER
12. Name: John R. Menke
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Catherine Barbara
15. Birthplace: Penna.

18. Informant: John Ebaug
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-4-40 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Greenmount Md

18. Funeral director: Jacob Winks Sons
Address: Winchester Md

19. Apr. 3 1940 (Date rec'd by registrar) Mildred S. Hughes (Deputy) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2nd 1940 at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10th 1939 to April 2nd 1940 and that I last saw h~~e~~ alive on April 2nd 1940

Immediate cause of death	DURATION
Bronchial Pneumonia	4 days
Due to	
Due to	
Other conditions Arterio Sclerosis	8 Mo.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. D M Resh M. D. or other
Address: Hampstead Md Date signed 4/3/40

RECEIVED
APR 15 1940
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-L)

CERTIFICATE OF DEATH

04090

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 16 yrs 11 mos 12 days

Stay in this community (yrs., or mos., or days) 16 yrs 11 mos 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Montgomery

City or town Bethesda R.F.D # 2 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Irving Foster Eglin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1895

8. AGE:

Years	Months	Days	If less than one day
44	8	24	hrs. min.

9. Birthplace Montgomery County Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Maurice Eglin

13. Birthplace Montgomery County Md

MOTHER 14. Maiden name Nora Cotter

15. Birthplace Ireland

16. Informant Hospital Records

Address Sykesville Md.

17. Burial Date thereof 4-12-40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Springfield Hosp. Cemetery

Location Sykesville Md.

18. Funeral director C. Harry Weer

Address Sykesville Md.

19. 4-12- 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1939, to April 8 1940, and that I last saw him alive on April 8 1940.

Immediate cause of death Pulmonary Tuberculosis — DURATION July 1928

Due to

Due to

Other conditions Mental Deficiency

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Max Hayman M. D. or other

Address Springfield State Hosp Date signed 4/9/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04091

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 7 Park Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 88-11-27

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 7 Park Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Irene Englar

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Theodore F. Englar

6(c) If alive, give age 95 years

7. Birth date of deceased (mo., day, yr.) April 20th, 1851

8. AGE: Years	Months	Days	If less than one day
88	11	27	hrs. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation House-wife

11. Industry or business

FATHER
12. Name John Roop, Jr.
13. Birthplace Maryland

MOTHER
14. Maiden name Lydia Engel
15. Birthplace Maryland

16. Informant Lewis K. Woodward, M. D.

Address Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20th 40 (month) (day) (year)

Cemetery Meadow Branch

Location Near Westminster

18. Funeral director J. E. Myers, Jr.

Address Westminster, Md.

19. 4-18-1940 (Date rec'd by registrar) 19 L K Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1940, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939 to April 17 1940, and that I last saw her alive on April 17th 1940.

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis K Woodward M. D. or other

Address Westminster Date signed 4-18-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 3 1940
BUREAU V. S.

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04092

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 20 yrs., 4 mos., 18 days.
Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Mt. Washington.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: #

3. (a) FULL NAME: Leonard Feustle.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male.	White	Married.

6 (b) Name of husband or wife: Gertrude.
6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1890.

8. AGE:

Years	Months	Days	If less than one day
49.	7.	16.	____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Book Keeper.
11. Industry or business: B. & O. R. R.

FATHER
12. Name: Leonard Feustle.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Elizabeth Black.
15. Birthplace: Maryland.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30 1940 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Bel Air Road
18. Funeral director: C. H. Baer
Address: Sykesville Md.

19. April 28 1940 (Date rec'd by registrar) C. Harvey Baer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 1940., at 6.25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936., to April 27, 1940., and that I last saw him alive on April 27, 1940.

Immediate cause of death: Coronary Thrombosis. — DURATION: 4-27-40.

Due to: ____

Due to: ____

Other conditions: Essential Cardiac Hypertension. (Include pregnancy within 3 months of death) — 1930 (?).

Major findings:
Of operations:
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ____ Injured at work?

23. SIGNATURE: Harry F. Baer, M.D. (M. D. or other)
Address: Sykesville, Md. Date signed 4/27/40.

RECEIVED
MAY 1 1940
BUREAU V. M.

04093

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94C)

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Rural nr. Taylorsville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D. Woodbine, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ida Jane Fisher

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: late Joseph Fisher

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 18, 1858

8. AGE: Years: 81 Months: 3 Days: 25 If less than one day ____ hrs. ____ min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: John E. Evans
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Sarah A. Farrell
15. Birthplace: Maryland.

16. Informant: Mrs. Margaret Franklin

Address: R.D. # Westminster, Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Apr 16, 1940 (month) (day) (year)

Cemetery or crematory: Morgan Chapel

Location: near Woodbine, Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. April 16 1940 (Date rec'd by registrar) E. M. Farrow Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1940, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death: Angina Pectoris

Due to: I had never attended this woman before but from the history I get I understand she had been taking treatment for a heart condition previous to coming into this neighborhood about week ago.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: I died about five minutes before I saw her of the above cause is my belief.

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: L. C. Dilley M. D. or other

Address: New Windsor Date signed: 4/15/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

APR 27 1940
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

04094

Reg. Dist. No. 12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Myers Dist. (Littlestown R.F.D.)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Littlestown, Pa. R. D. 1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward Lawrence Formwalt

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Laura (Lemmon) Formwalt

6(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Dec. 18-1871

8. AGE:

Years	Months	Days	If less than one day
68	3	27	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name George A. Formwalt

FATHER 13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Susanna Mottet

MOTHER 15. Birthplace Carroll Co. Md.

16. Informant Mrs. Laura E. Formwalt

Address Littlestown Pa. R.D.#1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April-18-1940 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Silver Run. Md.

18. Funeral director J. W. Slade & Son

Address Littlestown, Pa. R.D.#1.

19. April 16 1940 (Date rec'd by registrar) Calvin E. Benner, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1940, at 11-45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1940, to Sept 15 1940, and that I last saw him alive on Sept 15 1940.

Immediate cause of death	DURATION
hypocarditis	1 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. L. Crouse M D
M. D. or other

Address Littlestown Date signed Sept 16-'40

RECEIVED
MAY 4 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04095

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mo.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: David H. Frank Porter

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 21, 1853

8. AGE:

Years	Months	Days	If less than one day
87	0	8	hrs. min.

9. Birthplace: Baltimore Co. Md.

(Town, county, and state)

10. Usual occupation: Retired Farmer.

11. Industry or business

FATHER

12. Name: Conrad Brant Porter

13. Birthplace: Maryland.

MOTHER

14. Maiden name: Mary Pickle

15. Birthplace: Penna.

16. Informant: Mrs. Pearl Thompson

Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1940 (month) (day) (year)

Cemetery or crematory: Manchester Union

Location: Manchester, Md

18. Funeral director: C. M. Walter

Address: Westminster Md

19. Apr. 30 1940 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1940, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1939 to April 29 1940 and that I last saw him alive on April 28 1940

Immediate cause of death	DURATION
Cerebral Embolism	3 days
Due to: Chr. Endocarditis	?
Due to:	
Other conditions: Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.: none

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Gratill M. D. or other

Address: Emrainy Md Date signed 4/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (164C)

04096

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Westminster R.F.D.6
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Westminster R.F.D. # 6
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Harry Clinton Frick

3. (b) Social Security Number: none

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary Reese Frick
6(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): January 30, 1882
8. AGE: Years 58 | Months 2 | Days 4 | If less than one day ___ hrs. ___ min.
9. Birthplace: Maryland Carroll County (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER
12. Name: Frank Frick
13. Birthplace: Maryland
MOTHER
14. Maiden name: Rebecca Rosenberger
15. Birthplace: Maryland
16. Informant: Mrs. Mary Reese Frick
Address: Westminster, Md. R.F.D. #6
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 6-1940 (month) (day) (year)
Cemetery or crematory: Trinity Luthern
Location: near Smallwood, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 4/4 1940 (Date rec'd by registrar) L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1940, at 10 A.M. Prior to
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___,
and that I last saw h___ alive on ___ 19___.
Immediate cause of death: Gunshot wound left Chest
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy: none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: Apr 3-40
Where did injury occur? Nr Westminster (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Gunshot Injured at work? No.

23. SIGNATURE: Jas. T. Marsh Deputy Medical Examiner M. D. or other
Address: New Windsor Md Date signed: 4/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (I) (M)

RECEIVED
MAY 4 1940
BUREAU V. S.

04097

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(92L)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 4-yr 2 mo 8 da

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 761 So. Potomac St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth May Frowenfelter

3. (b) Social Security Number

4. Sex F.

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles Frowenfelter

6(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) May 15, 1870

8. AGE: Years 69 Months 10 Days 22 If less than one day ____ hrs. ____ min.

9. Birthplace Sharpsburg Maryland
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER
12. Name William Furley
13. Birthplace Maryland.

MOTHER
14. Maiden name Caroline Burgesser
15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/9/40 (month) (day) (year)

Cemetery or crematory Rest Haven Plan

Location Hagerstown - Md.

18. Funeral director Fred W Kraiss

Address Hagerstown Md.

19. 4-7- 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1940, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18 1936, to Apr. 6 1940, and that I last saw her alive on Apr. 6 1940.

Immediate cause of death

	DURATION
Arteriosclerosis	1936
Due to Chronic Valvular	1936
Due to Heart Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M D
M. D. or other

Address Sykesville Date signed 4-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(T)

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

04098

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Sarah A. Green

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: George Green

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18th, 1876

8. AGE: Years	Months	Days	If less than one day
63	10	29	hrs. min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Samuel Rheubottom

13. Birthplace: Md.

MOTHER 14. Maiden name: Mary Cook

15. Birthplace: Md.

16. Informant: George Green

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 20th, 1940 (month) (day) (year)

Cemetery or crematory: White Rock

Location: Carroll Co. Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Apr 18 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/17 1940, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1939, to Apr 17 1940, and that I last saw h-- alive on Apr 17 1940.

	DURATION
Immediate cause of death: Oedema of the Lungs	
Due to: Diabetes Mellitus	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. H. Barnes MD M. D. or other

Address: Sykesville Md Date signed 4/18/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04699

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 0yrs., 4mos., 0days.
Stay in this community (yrs., or mos., or days): Same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Carroll.
City or town: Hampstead, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Walter D. Hanson.

3. (b) Social Security Number: #

4. Sex: Male.

5. Color or race: White.

6.(a) Single, married, widowed, or divorced: Married.

6 (b) Name of ~~husband or~~ wife: Jennie Hoffacker.

6(c) If alive, give age: Unk. years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1863.

8. AGE: Years: 77. Months: 2. Days: 11. If less than one day: ____ hrs. ____ min.

9. Birthplace: Howard Co., Md.
(Town, county, and state)

10. Usual occupation: Cigar Manufacturer.

11. Industry or business: Proprietor.

FATHER
12. Name: Walter Hanson.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Ridgely.
15. Birthplace: Maryland.

16. Informant: Springfield State Hospital.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-27-40 (month) (day) (year)
Cemetery or crematory: Manchester Cemetery
Location: Manchester Md.

18. Funeral director: Jacob Winks Sons
Address: Manchester Md.

19. 4-25-40 (Date rec'd by registrar) 19 C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1940, at 11:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1940, to April 24, 1940, and that I last saw h im alive on April 24, 1940.

f immediate cause of death: Chronic Myocarditis prior to 12-24-39. — DURATION

Due to

Due to

Other conditions: General Arterio-sclerosis. prior to 12-24-39.
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Harry F. Baer, M.D.
M. D. or other
Address: Sykesville, Md. Date signed 4/24-40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

04100

Reg. Dist. No. 79

1. PLACE OF DEATH:
County Carroll
City or town Middleburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Miss Sarah E.Harbaugh

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6 (b) Name of husband or wife none
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.18,1868

8. AGE: Years	Months	Days	If less than one day
71	4	5	hrs. min.

9. Birthplace Frederick County
(Town, county, and state)
10. Usual occupation housework
11. Industry or business same

FATHER
12. Name Samuel F.Harbaugh
13. Birthplace Md.

MOTHER
14. Maiden name Mary E.Anders
15. Birthplace Md.

16. Informant Frank G.Harbaugh
Address Middleburg,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr.25,1940 (month) (day) (year)
Cemetery or crematory Cemetery
Location Woodsboro,Md.

18. Funeral director C.O.FUSS & SON
Address Taneytown,Md.

19. 4/23/ (Date rec'd by registrar) 19 40 Mrs. Rhea S. Dillon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-20 1940, to 4-23 1940, and that I last saw h alive on 19

Immediate cause of death Chr Myocarditis — DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. H Lugg M. D. or other
Address Union Mills Date signed 4-23-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04101

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 3 mos., 5 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Annapolis Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Blanche Hawkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Thomas Hawkins
6(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): May 20, 1920

8. AGE: Years	Months	Days	If less than one day
19	10	16	hrs. min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation: Maid

11. Industry or business:

FATHER
12. Name: John Jones
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Marie Johnson
15. Birthplace: Annapolis, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 9 1940 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis
18. Funeral director: J. B. Johnson
Address: Annapolis

19. 4/5/40 (Date rec'd by registrar) 19 Albert R. Swankham Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1940, 19, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29, 1939 to ~~April~~ March 5, 1940, and that I last saw her alive on ~~March~~ March 5, 1940, 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 1939

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 4/5/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-P)

04102

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 yrs., 10 mos., 12 days

Stay in this community (yrs., or mos., or days) 2 yrs., 10 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 229 Fauvale St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lena Heibeck

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 76 | Months | Days | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden name ?

15. Birthplace

16. Informant Mrs. Margaret Rodgers

Address 229 Fauvale St., Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 30 1940 (month) (day) (year)

Cemetery or crematory Greenmount

Location Greenmount Ave - Baltimore

18. Funeral director Harry A. Wiltse

Address 4101 Edmondson Ave

19. Apr 29 19 40 Harry Keer (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1940, at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1940, to April 29, 1940, and that I last saw her alive on April 28, 1940

Immediate cause of death	DURATION
Intestinal obstruction	1 day
Generalized arteriosclerosis	3 yrs (known)
Due to Adhesions between the omentum and posterior peritoneum	
Due to not due to cancer. Q.M.S.P.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Intestinal obstruction Generalized arteriosclerosis

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph N. Marshall, M.D. M. D. or other

Address Springfield State Hospital Date signed 4-29-40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04103

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 2 months, 7 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1332 Presstman Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Elizabeth Hill

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29, 1900

8. AGE:

Years	Months	Days	If less than one day
38	11	1	hrs. min.

9. Birthplace: Chesapeake Beach, Maryland (Town, county, and state)
10. Usual occupation: Laundry Worker
11. Industry or business

FATHER
12. Name: Benjamin Jones
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Cora Russell
15. Birthplace: Kingston, Jamica; West Indies

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-3-40 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Sandykonge - Md.
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St.

19. 4/30/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION 6:20 A.M.

20. DATE OF DEATH: April 30, 1940 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23, 1940 to April 30, 1940
and that I last saw h er alive on April 30, 1940

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Nov. 1939
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed 4/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

04104

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Lykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 6 days

Stay in this community (yrs., or mos., or days) 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County ~~Carroll~~ Frederick

City or town Frederick Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 422 N. Market St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John J. Hoffman

3. (b) Social Security Number 214-10-5239 → None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife unk.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 8 1879

8. AGE: Years 60 Months 8 Days 7 If less than one day ____ hrs. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Coal salesman

11. Industry or business

FATHER 12. Name John Francis Hoffman

13. Birthplace Maryland

MOTHER 14. Maiden name Martha Nitter

15. Birthplace Maryland

16. Informant Hospital Records

Address Lykesville, Md.

17. Entombment (Burial, cremation, or removal. Which?) Date thereof Apr. 18th, 1940 (month) (day) (year)

Cemetery or crematory Frederick Mem. Cloister

Location Frederick, Md.

18. Funeral director M. R. Etchison Son

Address 106 East Street Frederick Md

19. Apr 15 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1940, at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1940, to April 15 1940, and that I last saw him alive on April 15 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	10 years
Due to Coronary Sclerosis	"
Due to	
Other conditions Chronic Bronchitis (Include pregnancy within 3 months of death)	5 years

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE Max Hayman M. D. ~~or other~~

Address Springfield State Hosp. Date signed 4/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04105

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 11 mos., 26 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 34 Pleasant St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Dalton Brodgen Howard

3. (b) Social Security Number 212-14-1746

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret Howard

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 1, 1915

8. AGE: Years 24 | Months 8 | Days 13 | If less than one day ____ hrs. ____ min.

9. Birthplace Annapolis, Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Frank Howard
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden name Louise Brodgen
15. Birthplace Annapolis, Maryland

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 18 1940 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location on Washington Rd outside Annapolis

18. Funeral director Chas. H. Alexander

Address 43145 Northwest St Annapolis Md

19. 4/14/40 19 (Date rec'd by registrar) Albert R Swankhouse Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1940 19 7:05 P.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 1939 19 to April 14, 1940 and that I last saw him alive on April 14, 1940 19

Immediate cause of death Pulmonary Tuberculosis

Due to --

Due to --

Other conditions --

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy --

DURATION Nov. 1937

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Superintendent

Address Henryton, Maryland Date signed 4/14/40

RECEIVED
APR 23 1940
BUREAU V. S.

04106

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 2 mos., 3 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 639 W. Franklin Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3.(a) FULL NAME Mattie Jones

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1911

8. AGE:

Years	Months	Days	If less than one day
28	3	24	hrs. min.

8. Birthplace Camden, South Carolina (Town, county, and state)

10. Usual occupation Cook

11. Industry or business

FATHER 12. Name Thomas Jones

13. Birthplace South Carolina

MOTHER 14. Maiden name Mattie Wood

15. Birthplace South Carolina

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/40 (month) (day) (year)

Cemetery or crematory

Location Camden S.C.

18. Funeral director Adolphus Halsted

Address 918 Dund Hill Ave.

19. 4/19/40 19 (Date rec'd by registrar) Albert R. Swankhouse Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1940 19 , at 1:45 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16, 1940 19 to April 19, 1940 and that I last saw her alive on April 19, 1940 19

Immediate cause of death Pulmonary Tuberculosis

Due to --

Due to --

Other conditions --

(Include pregnancy within 3 months of death)

Major findings: --

Of operations

Of autopsy --

DURATION Jan. 1940

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. Superintendent M. D. or other

Address Henryton, Maryland Date signed 4/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

04107

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Mt. Airy, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 55 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R.D. Mt. Airy, Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Robert Jones

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife: Mary Jones

6(c) If alive, give age: ~~years~~

7. Birth date of deceased (mo., day, yr.): 1844 ?

8. AGE:

Years	Months	Days	If less than one day
95	—	—	____ hrs. ____ min.

9. Birthplace: Washington D. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mrs. Eugene Jones
Address: R.D. # Mt. Airy, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12, 1940 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Mt. Airy, Carroll Co. Md

18. Funeral director: C.M. Waltz
Address: Winfield, Md

19. Apr 12 1940 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1940, at 10:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1940, to April 9 1940, and that I last saw h was alive on April 7 1940.

	DURATION
Immediate cause of death: Chr. Nephritis	5
Due to: Chr. Myocarditis	?
Due to: Arterio - Sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. or other
Address: Mt Airy Md Date signed 4/10/40

RECEIVED
MAY 6 1910
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-c)

04675

CERTIFICATE OF DEATH

Reg. Dist. No. 81.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll.

City or town Union Bridge

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Union Bridge Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2 - 1940

8. AGE: Years | Months | Days | If less than one day: hrs. 15 min.

9. Birthplace Union Bridge (Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER 12. Name Robert F. Jones

FATHER 13. Birthplace Union Bridge Md

MOTHER 14. Maiden name Mary E. Thomas

MOTHER 15. Birthplace South Carolina

16. Informant Mary E. Jones

Address Union Bridge

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 3 - 1940 (month) (day) (year)

Cemetery or crematory Mt. Alive.

Location Oak Orchard - Liberty - New Windsor Road

18. Funeral director D. D. Hartsland Sons

Address Union Bridge Md

19. Apr. 2, 1940 (Date rec'd by registrar) R. Eichenauer Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1940, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death Strangulation -

Due to Homicidal, Cord Wound around the neck

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jno. J. Shorb - Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 4/2/40

RECEIVED
MAY 16 19..
BUREAU V. S.

RECEIVED
MAY 16 1900
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04108

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 mos., 3 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 534 Sanford Place

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Bernard William Jordon

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Eva Jordon

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13, 1918

8. AGE:

Years	Months	Days	If less than one day
21	11	6	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Daniel Jordon

13. Birthplace: unknown

MOTHER — 14. Maiden name: Margaret Taylor

15. Birthplace: unknown

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/23/1940 (month) (day) (year)

Cemetery or crematory:

Location: Lancaster, Va.

18. Funeral director: T. E. Kelson

Address: 1303 Pressman St

19. 4/19/40 (Date rec'd by registrar) 19 Albert R. Swanklow Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 1940 19 , at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16, 1940 to April 19, 1940, and that I last saw him alive on April 19, 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings: --

Of operations:

Of autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.

Address: Henryton, Maryland Title: Superintendent or other

Date signed: 4/19/40

RECEIVED
APR 25 1940
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04109

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 yrs., 11 mos., 5 days

Stay in this community (yrs., or mos., or days) 2 yrs., 11 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 110 E. Madison

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Margaret Kelly

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 24, 1869

8. AGE: Years	Months	Days	If less than one day
70	10	9	____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Saleslady

11. Industry or business: Department stores

FATHER 12. Name: John Kelly

13. Birthplace: ?

MOTHER 14. Maiden name: Mary Cunningham

15. Birthplace: Ireland

16. Informant: Miss Alice Kelly

Address: 806 N. Calvert St., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-5-40 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Balto. Md.

16. Funeral director: Wm. Cook

Address: 1217 St Paul St. Balto. Md.

19. 4-3-40 (Date rec'd by registrar) 19 ____ C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1940, at 5:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 1937, to April 2, 1940, and that I last saw her alive on April 2, 1940

Immediate cause of death	DURATION
Hypostatic pneumonia	3 days
Hypertensive cardio vascular disease	9 yrs.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	9 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: Hypostatic pneumonia. Cerebral arteriosclerosis

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 4-3-40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(95c)

04110

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 79

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 200 Penn. Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Annie A. E. King

3. (b) Social Security Number none

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Jacob Wesley King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 - 1860

8. AGE: Years 79 Months — Days 12 If less than one day hrs. min.

9. Birthplace N. Westminster, Carroll, Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Jacob Miller
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Burgoon
15. Birthplace Maryland

16. Informant Mr. William M. King

Address Liberty St. Westminster, Md.

17. Burial Date thereof April 20-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Kriders

Location N. Westminster Maryland

18. Funeral director H Bankard & Son

Address Westminster Md

19. 4/19 1940 F. L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1940, to April 17 1946 and that I last saw h alive on 19

Immediate cause of death Organic Heart Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Stewart M. D. or other

Address Westminster Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(T)

RECEIVED
MAY 4 1960
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04111

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 mos., 21 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Howard Lane

3. (b) Social Security Number: 214-12-5031

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1915

8. AGE:

Years	Months	Days	If less than one day
24	4	14	hrs. min.

9. Birthplace: Gross, Md., Talbot County
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Charlie Lane
13. Birthplace: unknown

MOTHER
14. Maiden name: Fannie Blackwell
15. Birthplace: unknown

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-13-40 (month) (day) (year)

Cemetery or crematory: Easton

Location: Easton Md.

18. Funeral director: C. Harry Weir

Address: Sykesville Md.

19. 4/10/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1940 10:20 A.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 20, 1939, to April 10, 1940 and that I last saw him alive on April 10, 1940 19

Immediate cause of death	DURATION
Ventricular Fibullation	Immediately
Due to --	
Due to --	
Other conditions: Pulmonary Tuberuclosis	July 1939

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed 4/10/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04112

Reg. Dist. No. 26

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 5-S Carroll St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 5-S Carroll
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John S. Leister

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband~~ or wife Virginia Leister
6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) December 1-1865

8. AGE:

Years	Months	Days	If less than one day
74	4	7	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired farmer
11. Industry or business
FATHER 12. Name Nathaniel Leister
13. Birthplace Maryland
MOTHER 14. Maiden name Lydia A. Keller
15. Birthplace Maryland.
16. Informant Mrs John S Leister
Address Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10-1940 (month) (day) (year)
Cemetery or crematory Westminster
Location Westminster, Md
18. Funeral director Edw C Tipton
Address Hampstead, Md
19. 4/9 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1940, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 1939, to April 8 1940, and that I last saw him alive on April 8 1940.

Immediate cause of death Myocardial degeneration-Valvular Insufficiency-Decompensation

Due to Arteriosclerosis General. — DURATION ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md Date signed April 8/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAY 4 1910
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

04113

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 yr., 6 mos., 26 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1075 W. Lexington St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Laura Lewis

3. (b) Social Securily Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

8 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1924

8. AGE: Years	Months	Days	If less than one day
16	1	10	hrs. min.

9. Birthplace: Darlington, South Carolina
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business

FATHER
12. Name: Samuel Lewis
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Pearl Mullrow
15. Birthplace: South Carolina

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-24-40 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Arbutus P. O. Md.

18. Funeral director: Mrs. K. R. Williams
Address: 322 N. Schroeder St

19. 4/20/40 (Date rec'd by registrar) 19 Albert R. Swankhouse Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1940 19 1:05 P.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25, 1938 19 to April 20, 1940 19, and that I last saw her alive on April 20, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1937

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause fo which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D.
Superintendent
M. D. or other
Address: Henryton, Maryland Date signed 4/20/40

RECEIVED
MAY 4 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-D)

04114

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 mo. 7 days

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 314 Avirett Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Elizabeth Logsdon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1909

8. AGE:

Years	Months	Days	If less than one day
30	11	1	hrs. min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Allen Logsdon
13. Birthplace Maryland

MOTHER
14. Maiden name Bridget Kelly
15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Apr. 30 1940
(month) (day) (year)

Cemetery or crematory Cumberland

Location Md.

18. Funeral director H. Barnard & Son

Address Westminster Md.

19. Apr. 27 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27th 1940, at 1:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20th 1940, to April 27th 1940 and that I last saw her alive on April 27th 1940.

Immediate cause of death Pulmonary Embolism

Due to Carcinoma of Rectum Metastasis to Right Lung

Due to

Other conditions Epilepsy

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Pulmonary Embolism - Carcinoma Rectum & Metastasis to Lung.

DURATION
April 27 - 1940 -
April 8 - '40 Known
April 27 - 1940 -
27 years.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other

Address Sykesville, Md. Date signed April 27 - '40

RECEIVED
MAY 4 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

(I)

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

04115

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 days

Stay in this community (yrs., or mos., or days): 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Liberty St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Theckla John Marsh

3. (b) Social Security Number: 214-07-3521

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lizzie Wise

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Mar 22 1874

8. AGE: Years: 66 Months: 0 Days: 24 If less than one day ____ hrs. ____ min.

9. Birthplace: W. Virginia
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Unk

FATHER
12. Name: Sector Marsh
13. Birthplace: Ohio

MOTHER
14. Maiden name: Olive Berry
15. Birthplace: Unk

16. Informant: Hospital Records

Address: Sykesville Md.

17. Removal
(Burial, cremation, or removal. Which?)

Date thereof: Apr. 15 1940
(month) (day) (year)

Cemetery or crematory: Rosa Hill Cemetery

Location: Cumberland Md.

18. Funeral director: V. L. Lempereur

Address: Cumberland Md.

19. Apr 15 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1940, at 2:53 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1940, to April 15 1940, and that I last saw him alive on April 15 1940.

Immediate cause of death	DURATION
Acute Myocarditis	1 day
Due to Coronary Sclerosis	years
Due to	
Other conditions L leg amputated	years

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Max Hayman M. D. ~~or other~~

Address: Springfield State Hosp. Date signed: 4/15/40

RECEIVED
APR 23 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

04116

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Mt. Gamber
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Mt. Gamber Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martha J. McCauly

3. (b) Social Security Number none

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Harry G. McCauly

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10 - 1868

8. AGE: Years 71 Months 5 Days 3 If less than one day hrs. min.

9. Birthplace Laurel, Prince George, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Dennis S. Bounds
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Roby
15. Birthplace Maryland

16. Informant Mrs Harry N. Wilmer

Address Flohrville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof April 16 - 1940
(month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikesville Baltr. Co. Maryland

18. Funeral director H Bankard & Son

Address Westminster, Maryland

19. 4/15 1940 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1940, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/7 1940, to 4/13 1940, and that I last saw her alive on 4/13/40 - 19

Immediate cause of death Acute Coronary Thrombosis - DURATION 6 days.

Due to

Due to

Other conditions Advanced Myocarditis Genial Cesteria Sclerosis 10 yrs.
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Shuster Bow M.D.
M. D. or other

Address Westminster Md. Date signed 4/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

04117

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 1yr. 4 mos. 19 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Finksberg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harrison Alfred Mercer

3. (b) Social Security Number 215-18-1493

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1918

8. AGE: Years	Months	Days	If less than one day
21	6	29	hrs. min.

9. Birthplace Union Bridge, Maryland, Carroll Co.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Earl Mercer
13. Birthplace Union Bridge, Maryland
MOTHER 14. Maiden name Mary Black
15. Birthplace Union Bridge, Maryland
16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 14, 1940 (month) (day) (year)
Cemetery or crematory Old Fields
Location New Windsor - Liberty Road.
18. Funeral director D. D. Hartzler & Son.
Address Union Bridge, Md.
19. 4/11/40 19 (Date rec'd by registrar) Albert R. Swankham Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1940 19 1:15 P.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 23, 1938 19 to April 11, 1940 and that I last saw him alive on April 11, 1940 19

Immediate cause of death Pulmonary tuberculosis — DURATION Sept. 1935
Due to --
Due to --
Other conditions --
(Include pregnancy within 3 months of death)
Major findings: --
Of operations
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Superintendent
Address Henryton, Maryland Date signed 4/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04118

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 month, 7 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 543 Mosher St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Harvey Moses

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

B (b) Name of husband or wife: Edith Moses
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 27, 1899

8. AGE:

Years	Months	Days	If less than one day
40	3	17	hrs. min.

9. Birthplace: Cape Charles, Virginia
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER
12. Name: Nathaniel Moses
13. Birthplace: Virginia

MOTHER
14. Maiden name: Katherine Florry
15. Birthplace: Virginia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-17-40 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Balto City Md.

18. Funeral director: Mrs. Geo. H. Holland
Address: 1631 Druid Hill Ave

19. 4/13/40 (Date rec'd by registrar) 19 Albert R Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1940 19 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1940 19 to April 13, 1940
and that I last saw him alive on April 13, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? --
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed 4/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 23 1940
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04119

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 month, 21 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 313 N. Carey St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William Outley

3. (b) Social Security Number: 218-07-2322

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1912

8. AGE:

Years	Months	Days	If less than one day
27	7	22	hrs. min.

9. Birthplace: Cotton Dale Farm, Florida
(Town, county, and state)

10. Usual occupation: Presser

11. Industry or business

FATHER
12. Name: William Outley
13. Birthplace: Florida

MOTHER
14. Maiden name: Orzia Russ
15. Birthplace: Cotton Dale, Florida

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Buried Date thereof 4/27/1940 (month) (day) (year)
Cemetery or crematory: Mt Zion Cemetery
Location: Balto Md.

18. Funeral director: Mrs Katie A. Williams
Address: 322 N. Schroeder St.

19. 4/25/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25, 1940 19 , at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4, 1940 19 , to April 25, 1940 19 , and that I last saw him alive on April 25, 1940 19 .

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1940

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --

Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? --
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent
M. D. or other
Address: Henryton, Maryland Date signed 4/25/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

04129

Reg. Diat. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 4 mos., 24 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 17 Calvert Court
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Jessie Pack

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

B (b) Name of husband or wife: Horace Pack

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1898

8. AGE: Years	Months	Days	If less than one day
41	6	21	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Howard Smith
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sara Johnson
15. Birthplace: Bermuda Hundred, Virginia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/29/40 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Annapolis Md.

18. Funeral director: Mrs Geo A. Holland

Address: 1431 Druid Hill Ave

19. 4/25/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION 9:50 P.M.

20. DATE OF DEATH: April 25, 1940 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1939 19 to April 25, 1940 19, and that I last saw her alive on April 25, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) -- (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury -- injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Superintendent Henryton, Maryland Date signed 4/25/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04121

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1 yr., 5 mos., 17 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2305 Madison Avenue

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Elmer Payne

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Margaret Payne

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1915

8. AGE: Years	Months	Days	If less than one day
24	10	17	hrs. min.

9. Birthplace: Gladys, Virginia (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER — 12. Name: James Payne; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Ora Bradley; 15. Birthplace: Virginia

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 19th, 1940 (month) (day) (year)

Cemetery or crematory: Lynchburg

Location: Virginia

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. 4/15/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1940, 19, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28, 1938, 19, to April 15, 19 1940 and that I last saw him alive on April 15, 1940, 19.

	DURATION
Immediate cause of death: Pulmonary tuberculosis	June 1938
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) -- (State)

Injured at home, farm, industry, public place (where?):

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

M. D. or other

Address: Superintendent Henryton, Maryland Date signed: 4/15/40

RECEIVED
APR 20 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04122

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Home for Aged Cor. Main & Church Sts.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 8 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: ~~Carroll~~

City or town: ~~Westminster~~ Baltimore Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: ~~Cor. Main & Church Sts.~~ (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Henrietta Pearce

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 11, 1861

8. AGE: Years 78 Months 5 Days 27 If less than one day: hrs. min.

9. Birthplace: Oella, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Manuel Pearce
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Miller
15. Birthplace: Maryland

16. Informant: Mrs. D. S. Gehr

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/10/40 (month) (day) (year)

Cemetery or crematory: Mount Olivet Cemetery

Location: Baltimore, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 4/8 1940 L. K. Woodward (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 7th 1940, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1939 to Apr 7 1940, and that I last saw her alive on Apr 7 1940.

Immediate cause of death: Coronary Embolism ~~[illegible]~~

Due to: Arterio Sclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: Few mins; more than 8 yrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. K. Woodward M. D. of

Address: Westminster Date signed: 4/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04123

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 2 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 613 N. Carrollton Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Reuben Alphonso Pope

3. (b) Social Security Number 220-05-8616

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 18, 1920

8. AGE:

Years	Months	Days	If less than one day
20	3	6	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Laborer in butter factory
11. Industry or business

FATHER
12. Name Shadrack Pope
13. Birthplace North Carolina

MOTHER
14. Maiden name Eunice Haley
15. Birthplace unknown

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-27-40 (month) (day) (year)
Cemetery or crematory
Location Hertford N. Cav.
18. Funeral director Mrs. Geo. H. Hoeland
Address 1631 Druid Hill Ave
19. 4/26/40 (Date rec'd by registrar) 19 Albert R. Swanklane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1940 19 , at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24, 1940 19 to April 26, 1940 19, and that I last saw him alive on April 26, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1940
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M. D.
M. D. or other
Address Superintendent Henryton, Maryland
Date signed 4/26/40

Deputy Local

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04124

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 day
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Oxen Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Carrie Frances Proctor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

8 (b) Name of husband or wife: Sidney Francis Proctor
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1898

8. AGE: Years	Months	Days	If less than one day
42	2	16	hrs. min.

9. Birthplace: Porterbacker, Chas. Co., Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: Sidney Proctor
13. Birthplace: Charles County

MOTHER 14. Maiden name: Carrie Proctor
15. Birthplace: Porterbacker, Chas. Co., Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29/40 (month) (day) (year)
Cemetery or crematory: Oxon Hill
Location: Oxon Hill Prince Geo Co Md
18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md

19. 4/26/40 (Date rec'd by registrar) 19 Albert R. Swanklaus Registrar
Deputy Local

MEDICAL CERTIFICATION 2:40 P.M.

20. DATE OF DEATH April 26, 1940 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25, 1940 19 to April 26, 1940 and that I last saw her alive on April 26, 1940 19

Immediate cause of death	DURATION
Miliary Tuberculosis	Feb/1940
The lungs were involved. c.w.s.R.	
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Superintendent Henryton, Maryland Date signed 4/26/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (138)

04125

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 mo., 27 days

Stay in this community (yrs., or mos., or days): 1 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 2823 Alameda Blvd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary Blanche Rine

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jesse Plummer Rine

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 5, 1876

8. AGE: Years: 63 | Months: 6 | Days: 17 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: John W. Hillmond

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Laura Wills

15. Birthplace: Baltimore, Md

16. Informant: Thomas M. Hillmond

Address: 2823 Alameda Blvd. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25, 1940 (month) (day) (year)

Cemetery or crematory: Londontown Cemetery

Location: Balto. Md.

18. Funeral director: Wm. Cook

Address: 1213 E. Pat St.

19. 4-22-40 (Date rec'd by registrar) C. Harry Reed (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22, 1940, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26, 1940, to April 22, 1940, and that I last saw her alive on April 22, 1940.

	DURATION
Immediate cause of death: Lobar pneumonia	6 days
Generalized arteriosclerosis	2 mos. (known)
Due to:	
Due to:	
Other conditions: Epilepsy	33 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: Lobar pneumonia

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. (M. D. or other)

Address: Springfield State Hospital Date signed: 4-23-40

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MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-a)

CERTIFICATE OF DEATH

04126

Reg. Diat. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Jordans Retreat (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 17 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Jordans Retreat Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John William Robertson

3. (b) Social Security Number 205-10-6512

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary Alice McClellan
6(c) If alive, give age abt 57 years

7. Birth date of deceased (mo., day, yr.) Dec. 10 - 1861

8. AGE: Years 78 | Months 4 | Days 8 | If less than one day ____ hrs. ____ min.

9. Birthplace Medford, Carroll, Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John Robertson
13. Birthplace Maryland

MOTHER 14. Maiden name Rebecca Arnold
15. Birthplace Maryland

16. Informant Jane Mary Robertson
Address New Windsor Maryland R.F.D

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21-1940 (month) (day) (year)
Cemetery or crematory Stone Chapel
Location Nr. Medford Carroll Co. Md.

18. Funeral director A. Bankard & Son
Address Westminster, Maryland

19. Apl 20 1940 (Date rec'd by registrar) Ernest Babylon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1938, to Apr 18 1940, and that I last saw him alive on Apr 17 1940.

	DURATION
Immediate cause of death Acute Cardiac Dilatation	minutes
Due to Hypertension Cardio-Vascular-Renal disease	yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: no
Of operations
Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jas. T. Maxwell M. D. or other
Address New Windsor Md Date signed 4/19/40

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MAY 8 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

04127

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Sallie G. Roop

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: Joel I. Roop

6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): April 2, 1872

8. AGE: Years	Months	Days	If less than one day
68	0	16	hrs. min.

9. Birthplace: Page County, Virginia
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Jesse C. Geiman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary A. Triplett
15. Birthplace: Virginia

16. Informant: Joel I. Roop
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/21/40 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Carroll County, Maryland

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 4/19 1940 (Date rec'd by registrar) L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 1940, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. — 1937 to Apr. 18th 1940, and that I last saw her alive on Apr. 18th 1940.

Immediate cause of death: Acute Dilatation of Heart, Uremic Coma — DURATION: 1 day

Due to: Cardiovascular Renal Disease — 3 yrs.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Lewis K. Woodward M. D. or other
Address: Westminster Date signed: 4/19/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (85)

04128

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 4 days.
Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore. Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1123 N. Central Ave.,
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR: #

3. (a) FULL NAME: Henry Ruppel.

3. (b) Social Security Number: #

4. Sex: Male.
5. Color or race: White.
6. (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: Agnes Sohlman.
6(c) If alive, give age: 43. years
7. Birth date of deceased (mo., day, yr.): April 30, 1896.

8. AGE: Years: 43. Months: 11. Days: 27. If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Machinist.
11. Industry or business:
FATHER
12. Name: Frederick Ruppel.
13. Birthplace: Maryland.
MOTHER
14. Maiden name: Louisa Schindelle,
15. Birthplace: Maryland.
16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1 1940 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Bel Air Road
18. Funeral director: William Cook
Address: 1217 Sx Paul Street
19. 4-28- 1940 (Date rec'd by registrar) C. Harry Wen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 1940, at 11:30 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23, 1940, to April 27, 1940, and that I last saw him alive on April 27, 1940.

Immediate cause of death: Status Epilepticus. DURATION: 4-23-40.
Due to: Epilepsy prior to 1-19-40.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D., M. D. or other
Address: Sykesville, Md. Date signed: 4-27-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MAY 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS.A15

(M)

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

04129

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:

County Carroll Co.

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 23 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll.

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Ridgeville Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no.

3. (a) FULL NAME Daniel B. Sheffer

3. (b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Almeda Sheffer

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1865

8. AGE:

Years	Months	Days	If less than one day
75	2	15	hrs. min.

8. Birthplace near York, Penna.

(Town, county, and state)

10. Usual occupation Retired Farmer.

11. Industry or business

FATHER

12. Name Samuel Sheffer

13. Birthplace Penna.

MOTHER

14. Maiden name Caroline Dinkle

15. Birthplace Penna.

16. Informant Mrs Almeda Sheffer

Address Ridgeville, Md.

17. Burial Date thereof April 29, 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dover Union Cemetery.

Location Dover Township, Penna.

18. Funeral director C. M. Waltz

Address Winfield, Md.

19. Apr. 27 1940 Wm D Snyder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1940, at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1940, to April 25 1940, and that I last saw him alive on April 24 1940.

Immediate cause of death Uremia

Due to Chr. Myocarditis

Due to Chr. Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION

6 wks

?

?

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J Stanley Grabill M. D. or other

Address Mt Airy Md Date signed 4/27/40

RECEIVED
MAY 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

04130

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:
County: Carroll
City or town: Pleasant Valley
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 75

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ____ County ____
City or town ____ Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME: Mrs Annie M. C. Starner
3. (b) Social Security Number: none

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Geo W. Starner
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Feb 24, 1861
8. AGE: Years 79 | Months 0 | Days 22 | If less than one day ____ hrs. ____ min.
9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER
12. Name: Absalom Zepp
13. Birthplace: Md
MOTHER
14. Maiden name: Eliza Stonesifer
15. Birthplace: Md
16. Informant: Maurice Starner
Address: Westminster Md R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/19/1940 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Pleasant Valley, Md.
18. Funeral director: Ch Fussl Son
Address: Taneytown, Md.
19. April 17th 1940 (Date rec'd by registrar) Calvin E. Bankert, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1940, at 10:12 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1940, to April 15 1940, and that I last saw her alive on April 15 1940.
Immediate cause of death: Hypertensive Cardio Renal disease Senile Dementia
Due to: Arteriosclerosis & Senility
Due to ____
Other conditions ____
(Include pregnancy within 3 months of death)
Major findings:
Of operations ____
Of autopsy ____

DURATION: ? May 10

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work? ____

23. SIGNATURE: W. Glenn Speicher M.D. or other
Address: Westminster Date signed Apr 17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (M) (T) (I)

RECEIVED
MAY 4 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04131

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (942)

County Carroll Registration Dist. No. 75

Village or City Manchester No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Julia Ann Stenner, If U. S. Veteran, specify WAR

(a) Residence: No. Manchester, Rfd St. R. D. Ward #1

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emory Stenner

6. DATE OF BIRTH (month, day, and year): Jan 19, 1860

7. AGE: Years 80 | Months 2 | Days 26 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.:

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Housewife

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Pa

FATHER

13. NAME: Phillip Roser

14. BIRTHPLACE (city or town) (State or country): Pa

MOTHER

15. MAIDEN NAME: Anna Houck

16. BIRTHPLACE (city or town) (State or country): Pa

17. INFORMANT (Address): Emory W. Stenner, Manchester, Md R#1

18. BURIAL, CREMATION, OR REMOVAL: Place Black Rock Cemetery Date April 18, 1940

19. UNDERTAKER (Address): H. A. Fricker Hanover, Pa

20. FILED Apr. 16, 1940 Mrs. H. P. L. Benner Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 15, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 1, 1940, to April 15, 1940

I last saw her alive on April 13, 1940; death is said to have occurred on the date stated above, at 12:10 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary thrombosis	

Other Contributory Causes of Importance:

Arteriosclerosis with Hypertension.

Name of operation: none Date of

What test confirmed diagnosis? Signs & symptoms Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Jul 3 Wentz M. D.

(Address) Hanover, Pa.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of **engineers** by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED MAY 6 1928 BUREAU OF

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04132

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 27 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Federalsburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Edward Sutton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife: unknown
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February, ?, 1882

8. AGE: Years: 58 | Months: 2 | Days: ? | If less than one day: hrs. min.

9. Birthplace: Ridgely, Caroline Co., Md.
(Town, county, and state)

10. Usual occupation: Farm labor

11. Industry or business:

FATHER
12. Name: William Sutton
13. Birthplace: Talbot County, Maryland

MOTHER
14. Maiden name: Louise Brickus
15. Birthplace: Virginia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal) Which? Date thereof 4-26-40 (month) (day) (year)
Cemetery or crematory: St Lukes Cemetery
Location: Sykesville Md.

18. Funeral director: C. Harry Weis
Address: Sykesville Md.

19. 4/23/40 (Date rec'd by registrar) 19 Albert R. Swanklaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 1940 19 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1940 19 to April 23, 1940 19 and that I last saw him alive on April 23, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
DI operations --
Df autopsy --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed 4/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1040
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04133

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Mt Airy, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R.D. Mt Airy, Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Zachariah D. Taylor

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife: Late Susan Taylor
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1873

8. AGE: Years	Months	Days	If less than one day
66	6	29	____ hrs. ____ min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Frank Taylor
13. Birthplace: Maryland
MOTHER 14. Maiden name: Matilda Welsh
15. Birthplace: Maryland
16. Informant: Mr. William E. Taylor
Address: Mt. Airy Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20 1940 (month) (day) (year)
Cemetery or crematory: Mt. Irene
Location: Mt Airy, Carroll Co. Md.
18. Funeral director: C.M. Waltz
Address: Westfield Md
19. Apr 19 1940 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17, 1940, at 1:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw him alive on April 15 1940.

Immediate cause of death	DURATION
6h. Cardiac decompensation	6 mo
edema & ascites	1 mo
Due to: Chr. Myocarditis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: J. Stanley Grabill
M. D. or other
Address: Mt Airy, Md Date signed 4/17/40

RECEIVED
MAY 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

04134

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Smallwood
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Smallwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Olive Teed

3. (b) Social Security Number None

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband ~~or wife~~ Daniel Teed
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 11 - 1850

8. AGE: Years 89 Months 11 Days 21 If less than one day hrs. min.

9. Birthplace Canada (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Archibald Cox
13. Birthplace Canada

MOTHER
14. Maiden name Esther Fisher
15. Birthplace Canada

16. Informant Mrs Mabel Sies
Address Smallwood, Carroll Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 1940 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Maryland
18. Funeral director H Bankard & Son
Address Westminster, Maryland

19. 4 3 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1940, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1939, to April 2nd 1940, and that I last saw her alive on April 2nd 1940.

Immediate cause of death Chronic Parenchymatous nephritis -
Due to
Due to
Other conditions Chr. Myocarditis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION 1 year

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Shuchee Bon M.D.
M. D. or other
Address Westminster Md. Date signed 4/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04135

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 month, 15 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1415 St. Matthews Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Lee Ora Thompson

3. (b) Social Security Number: 218-03-4833

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1917

8. AGE:

Years	Months	Days	If less than one day
22	9	3	hrs. min.

9. Birthplace: Chester S. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Bob Thompson
13. Birthplace: Chester, S. C.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-12-40 (month) (day) (year)
Cemetery or crematory: Piney Grove Cemetry
Location: Chester - S.C.

18. Funeral director: William a Jackson
Address: 916 Penn ave

19. April 7, 1940 (Date rec'd by registrar) Albert R Swinburne Local Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7, 1940 at 8:20 P.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22, 1940 19 , to April 7, 1940, and that I last saw h im alive on April 7, 1940 19

Immediate cause of death	DURATION
Pulmonary tuberculosis	Dec. 1939.
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 4/7/40

RECEIVED
MAY 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

04136

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 316 E. Main St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 316 E. Main St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Charles J. Ward

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Cora A. Shipley

6(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): February 25, 1876

8. AGE: Years	Months	Days	If less than one day
64	2	2	____ hrs. ____ min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: Trucker

11. Industry or business:

FATHER
12. Name: John T. Ward
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Devilbisss
15. Birthplace: Maryland

16. Informant: Mrs. Cora A. Ward
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/29/40 (month) (day) (year)

Cemetery or crematory: Westminster

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 4/29/40 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 1940, at 1a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1940, to April 27 1940, and that I last saw him alive on April 26 1940.

Immediate cause of death	DURATION
Heart failure	5 to 6 months
Due to Asthma	Life
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. Reese Wilkens M. D. or other

Address: Westminster Date signed: April 28 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAY 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04137

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1month, 15 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: ~~Henryton~~ Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1438 W. Lanvale St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ollie William Webb

3. (b) Social Security Number: 213-09-3557

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Webb

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 19, 1901

8. AGE: Years: 38 Months: 3 Days: 20 If less than one day: hrs. min.

9. Birthplace: Roxboro, N. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Robert Webb
13. Birthplace: Oxford, N. C.

MOTHER
14. Maiden name: Charlotte Day
15. Birthplace: Roxsboro, N. C.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-12-40 (month) (day) (year)

Cemetery ~~or crematory~~: [illegible]

Location: [illegible] Rocksborough N.C.

18. Funeral director: Saml. W. Chase & Son

Address: 638 N. Gilmor St. - Balto

19. 4/8/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8, 1940 3:40 P.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23, 1940 19 to April 8, 1940 and that I last saw him alive on April 8, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan 1940

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 4/8/40

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

04138

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 2 mos., 11 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Westover Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Harriet Elizabeth White

3. (b) Social Security Number: 213-16-8423

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Ernest White

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 16, 1900

8. AGE: Years	Months	Days	If less than one day
39	11	26	____ hrs. ____ min.

9. Birthplace: Westover, Somerset Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Daniel Ballard
13. Birthplace: Somerset County, Md.

MOTHER
14. Maiden name: Sarah Boston
15. Birthplace: Somerset County, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Apr 15 1940

Cemetery or crematory: Cottage Grove

Location: Westover Md

18. Funeral director: Chas H Ward

Address: Marion Md.

19. 4/11/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1940 10:30 P.M. 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31, 1940 to April 11, 1940 19 ____, and that I last saw her alive on April 11, 1940 19 ____

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Feb. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

Address: Henryton, Maryland M. D. or other: Superintendent

Date signed: 4/11/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAY 4 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04139

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Marriottsville Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) 2 yrs.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Marriottsville, Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME John Emory Widerman

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14th, 1850

8. AGE: Years	Months	Days	If less than one day
89	8	27	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name Samuel J. Widerman

13. Birthplace Md.

MOTHER 14. Maiden name Eleanor Hissey

15. Birthplace Md.

16. Informant Mrs. Lillian Tydings

Address Marriottsville, Md.

17. Burial Date thereof Mar. 12th 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olive Cem.

Location Randallstown, Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. 4-11-1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1940, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1940, to 4/11 1940, and that I last saw him alive on 4/10 1940.

Immediate cause of death	DURATION
Cardio Vascular Disease	
Due to	
Due to	
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H A Bruns M.D.
M. D. or other

Address Sykesville Md. Date signed 4/12/40

RECEIVED
APR 17 1940
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (83a)

Reg. Dist. No. 81

04140

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Union Bridge (Rural)
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) Lifetime

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Carroll

(c) City or town Union Bridge (Rural)
(If outside city or town limits, write RURAL and give town)

(d) Street No. Bark Hill
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Francis Ann Wilson

3 (b) If veteran, name war

3 (c) Social Security No. None.

4. Sex Female.

5. Color or race White.

6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Charles Thomas Wilson

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1858

8. AGE: Years 81 Months 5 Days 4 If less than one day ____ hr. ____ min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name David Routson
13. Birthplace Carroll Co. Maryland.

MOTHER
14. Maiden Name Susan Little
15. Birthplace Carroll Co. Maryland.

16 (a) Informant Elmer R. Wilson
(b) Address Union Bridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18 1940 (month) (day) (year)

(c) Cemetery or crematory Pipe Creek Cem.
Location Uniontown, New Windsor Md.

18 (a) Funeral director D. D. Hartsh & Sons
(b) Address Union Bridge, Md.

19 (a) Apr. 17 1940 (Date rec'd by registrar) (b) P. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. Date of death Apr 15 1940, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1940, to April 15 1940 and that I last saw him alive on April 14 1940.

Immediate cause of death Cerbral Hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature T. H. Legg M. D. or other

Address Union Bridge Date signed 4-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

(M)

(T)

RECEIVED
MAY 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04141

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 11 mos., 12 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 317 Madison St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Washington Wilson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Marie Wilson
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 28, 1900

8. AGE: Years	Months	Days	If less than one day
40	2	12	hrs. min.

9. Birthplace: Daisville, Maryland (Town, county, and state)
10. Usual occupation: Nurseryman
11. Industry or business

FATHER
12. Name: George H. Wilson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Vinie Smith
15. Birthplace: Maryland

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-12-40 (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Frederick, Maryland
18. Funeral director: C. E. Cline & Son
Address: Frederick - Md.

19. 4/9/40 (Date rec'd by registrar) 19 Albert R. Swankhaven Deputy Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9, 1940 1:40 P.M. 19, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21, 1939 19 to April 9, 1940, and that I last saw him alive on April 9, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Feb., 1939

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 4/9/40

RECEIVED
MAY 4 1940
BUREAU V. S.